Washington State Health Care Authority

Application for Apple Health for Kids Benefits

Washington Apple Health for Kids

This application is for medical coverage only for children and teens under 19. If you have questions or would like help filling out this form, just call 1-877-543-7669. We'll be happy to help you! Mail completed application to MEDS, PO Box 45531, Olympia, WA 98504-5531.

(List parent, guardian, or contact person who will receive follow-up information.)

1. FIRST NAME	MIDDLE INITIAL	LAST NAME		
2. ADDRESS WHERE YOU LIVE	STREET	CITY	STATE	ZIP CODE
3. MAILING ADDRESS (IF DIFFERENT)		CITY	STATE	ZIP CODE

4. HOME TELEPHONE NUMBER	WORK TELEPHONE NUMBER	MESSAGE TELEPHONE NUMBER	E-MAIL ADDRESS
( )	( )	( )	

5 Is everyone applying for benefits a Washington State resident? ☐ Yes ☐ No
If no, list who is not a resident:

6. Do you have trouble speaking, reading, or writing English and need an interpreter? ☐ Yes ☐ No
What language or alternative format do you need?

7. Do you need help paying for unpaid medical bills within the last 3 months for any of the children you are applying for? ☐ Yes ☐ No

8. Is anyone in your home pregnant? ☐ Yes ☐ No If yes, who? Due Date:

General Information

9. List family members **living together.** (If needed, attach a separate sheet of paper to list more family members).

NAME (FIRST, MIDDLE, LAST)	SEX M/F	RELATION TO YOU	BIRTH DATE (MM/DD/YY)	OPTIONAL FOR NON-APPLICANTS				
				SOCIAL SECURITY NUMBER	CHECK IF DOCU-MENTED ALIEN	CHECK IF U.S. CITIZEN	RACE *(see samples below)	TRIBE NAME (For American Indians, Alaskan Natives)
A. Parent, Guardian, or Self					☐	☐		
B. Spouse or Other Parent (If living in the home)					☐	☐		
C. List Children & Teens Under 19 Years of Age **(who want medical benefits)**					☐	☐		
D.					☐	☐		
E.					☐	☐		
F.					☐	☐		
G. List Any Adult/Child in the Home who does not want medical benefits.								

* Race and Ethnic background information is voluntary. Race examples: White, Black or African American, Asian, Native Hawaiian, Pacific Islander, American Indian, Alaska Native, or any combination of races. This information will not be used in considering your eligibility for benefits.

Expenses This information can help your children qualify. Do you pay the following expenses?

10. Do you pay for childcare or adult dependent care while you work, or do you pay court ordered child support for a child who is not living in your home? ☐ Yes ☐ No
If yes, how much per month? $ For who?

HCA 14-380 (1/12)

Barcode label

14380

Income Enter GROSS pay (before taxes or expenses). Please attach proof of recent income.

11. PARENT'S EMPLOYER NAME	TELEPHONE NUMBER ( )	START DATE

12. Amount you receive monthly before taxes and expenses are taken out: $

13. SPOUSE'S (OR OTHER PARENT LIVING IN THE HOME) EMPLOYER NAME	TELEPHONE NUMBER ( )	START DATE

14. Amount your spouse (or other parent living in the home) receive monthly before taxes and expenses are taken out: $

* If self-employed, you may verify income and expenses with your most recent tax return, including all schedules and attachments if it represents current/projected income.

Other Household Income	Average Amount Received Monthly	Which Family Member Earns This Income?	Other Household Income	Average Amount Received Monthly	Which Family Member Earns This Income?
15. Child Support/Alimony	$		16. Social Security Payment	$	
17. Unemployment Benefits	$		18. Veterans' Benefits	$	
19. Labor & Industries	$		20. Investment Income (Interest/Dividends)	$	
21. Other (Please Explain):				$	

Health Insurance Information Tell us about any health insurance your children already have.

22A. Do any of the **children** you are applying for already have health insurance? ☐ Yes ☐ No	22B. If "Yes," does that health insurance cover doctor, hospital, x-ray (radiology), and laboratory services? ☐ Yes ☐ No	23A. Have your **children** been covered by job-related health insurance in the last 4 months? ☐ Yes ☐ No	23B. If "Yes," list the monthly amount of premium for children: $

24. If you checked "Yes" to any of the above questions (22 A or B, or 23 A or B), please list the name of the insurance company or employer providing health insurance for your children.

INSURANCE COMPANY OR EMPLOYER	POLICY NUMBER	POLICY HOLDER'S NAME	POLICY HOLDER'S SOCIAL SECURITY NUMBER (OPTIONAL)

Optional Authorized Representative (Someone you allow the department to talk with about your benefits/receive letters).

If you would like to name a representative select one option below and complete representative information.

☐ Talk with the agency about your benefits; receive no letters. ☐ Talk to the agency about your benefits and receive letters.

NAME/ORGANIZATION		TELEPHONE NUMBER ( )
MAILING ADDRESS	CITY	STATE ZIP CODE

Read Carefully Before Signing

This application is for medical benefits for children only. If anyone in your family already receives, or would like to apply for cash benefits, basic food, or other benefits, please contact your local DSHS Community Services Office (CSO).

- The Agency or the Agency's designee may ask you to prove the information you are giving them to tell if you are eligible. You can ask the Agency or the Agency's designee for help in getting proof.
- Your information may be reviewed by other state or federal agencies. This information will NOT be shared with Immigration and Naturalization Services (INS).
- By asking for and getting health care benefits, you give the state of Washington all rights to any medical support and to any third party payments for health care.
- The Agency may share your child's immunization history with the Child Profile Immunization Tracking System.

DECLARATION AND SIGNATURE

I have read and understood the information in this application. I declare, under penalty of perjury, the information I have given in this application is true, correct, and complete to the best of my knowledge.

SIGNATURE OF APPLICANT	DATE